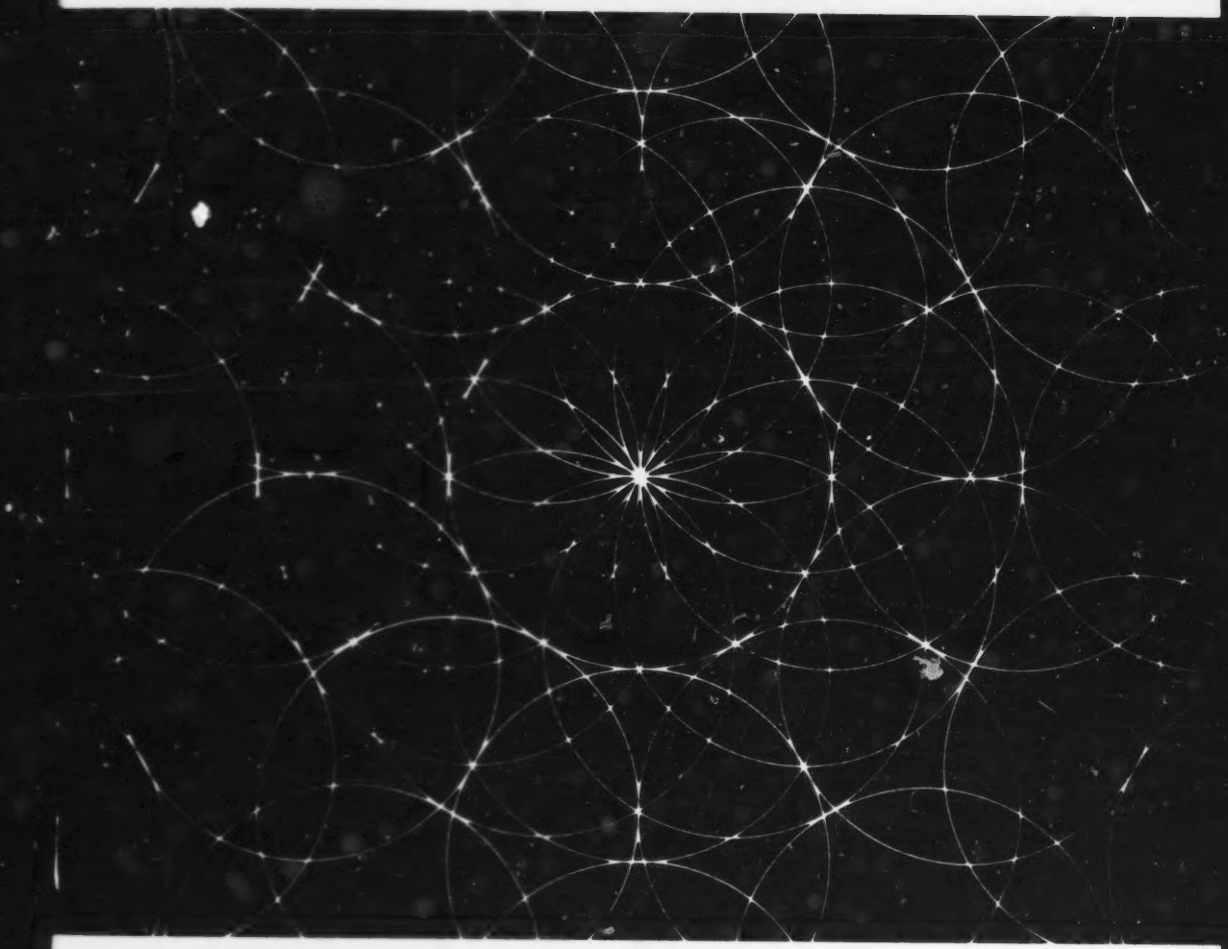
Report on

Medical Privilege

1983



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REPORT

ON

MEDICAL PRIVILEGE

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CHAPTER 1

INTRODUCTION

1.01 In July of 1978, the then Attorney-General referred the question of physician-patient privilege for the Commission's consideration. Specifically, the Commission was asked to consider the advisability of amending "The Manitoba Evidence Act", C.C.S.M. c. E150, to include a provision originally proposed by the Law Reform Commission of Canada in its 1975 Report on Evidence. The relevant provision is as follows:

> s. 41 A person who has consulted a person exercising a profession for the purpose of obtaining professional services, or who has been rendered such services by a professional person, has a privilege against disclosure of any confidential communication reasonably made in the course of the relationship if, in the circumstances, the public interest in the privacy of the relationship outweighs the public interest in the administration of justice.

1.02 The reference from the Attorney-General arose as a consequence of interest expressed by the Manitoba Medical Association in the applicability of s. 41 to physicians. That Association had approved a resolution of the General Council of the Canadian Medical Association:

> That the principle against disclosure by a duly qualified medical practitioner licensed to practise in the province, and set forth in section 41 of the suggested Evidence Act by the Law Reform Commission of Canada, be favourably considered for incorporation in the evidence laws throughout Canada.

1.03 The intent of s. 41 is to protect not only confidential communications between physician and patient, but also those between other professionals and their clients.[1] Inasmuch as this Report is generally

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[1]The term "professional" is not without difficulty. If, for instance, it is intended to include only those occupations which are self-governing, it would exclude social workers in Manitoba. It is at once wide enough to include an extremely broad range of professional relationships, and yet it may be too narrow to protect other relationships, not strictly professional in nature, for which a privilege might be justified in certain cases. See the discussion, infra at para. 4.03.

restricted to an analysis of privilege as it applies to physicians, it does not attempt to analyze the other professional relationships which might be included within s. 41. However, the Commission's discussion of medical privilege is also relevant to the issue of confidential communications within other relationships. This is largely because of the use by the Supreme Court of Canada, in the 1975 case of Slavutych v. Baker,[2] of a new and important test for the establishment of privilege. That test was first promulgated by the American authority on evidence, Dean Wigmore, and is designed to be applied, not only in the medical field, but to a wide range of relationships in which confidential communications arise. Thus, our conclusions about the developing nature of the common law may provide a perspective from which to view the problem of confidentiality within the other professional relationships included within s. 41.

1.04 At the outset of this Report, we wish to take the opportunity to thank those who have assisted us in our study by responding to our requests for information and opinions. We also wish to acknowledge the assistance of Ms. Leigh Halprin who acted as consultant to the Commission.

1.05 The format of this Report is as follows. In Chapter 2 we examine medical privilege as an issue of policy: we analyze the role played by privilege generally within the evidentiary framework of the law, and then consider medical privilege within that framework. Chapter 3 contains a detailed explication of the statutory and common law applicable in Manitoba. In Chapter 4 we consider to what extent the present law can be said to reflect the policies, and perform the functions, identified in Chapter 2. Chapter 5 contains a summary of our conclusions.

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[2][1976] 1 S.C.R. 254; 55 D.L.R. (3d) 224 (S.C.C.).

CHAPTER 2

THE POLICY OF THE LAW

2.01 The purpose of this Chapter is to consider to what extent it would be desirable for the courts to recognize a privilege for communications between patients and physicians. We examine privilege within the context of the general rules of evidence so that the arguments for medical privilege can be seen in perspective. We then analyze medical privilege specifically considering, first, several policy justifications for privilege; second, the American experience with a form of medical privilege; and third, the special situation of communications between patients and psychiatrists or other professionals when those professionals perform a similar counselling function.

A. Privilege Within the Evidentiary Framework

2.02 The fundamental concern of the trial process is to arrive at the truth. The court must first determine the facts of the particular occurrence, transaction or situation before it, and then apply the law to those facts. It must depend upon the testimony of witnesses, as well as upon documentary and other material evidence to establish what the facts are. To the extent that relevant evidence is not presented to the court, there is a risk that the court's decision will be based on a mistaken view of the facts.

2.03 In an attempt to minimize this risk, the law has established the essential principle that all evidence which is relevant to the determination of the issue, should be brought forward and considered unless excluded by some rule of the law of evidence. In practice, this means that the court has the power to summon witnesses, and require them to answer the questions that are put to them. Thus it is sometimes said that every individual is under a duty to give testimony on all matters at issue in a court of law.

2.04 To the general rule that all relevant evidence is admissible, however, there are two categories of exceptions. The first is a group of exclusionary rules designed to guard against evidence which is inherently unreliable or misleading. Thus the most important exclusionary rules - the hearsay rule, the rule excluding opinion evidence, and the best evidence rule - exist to reduce the likelihood of the court's relying on untrustworthy evidence in reaching its decision. These rules are concerned with ensuring that only the truth is received in evidence, and by so doing they help to maintain the essential integrity of the trial process.

2.05 The second category of exception is that of privilege. Privilege refers to the right or obligation of a party or a witness to refuse to reveal certain information or to produce documents requested at trial. Its protection may also be claimed at an interlocutory stage, and at examination for discovery. Unlike the other exclusionary rules, the various forms of privilege do not seek to assist in discovering the truth or the facts; instead, they operate as apparent impediments to the process of fact-finding. They are said to have as their object "the protection of interests and relationships which rightly or wrongly are regarded as of sufficient social importance to justify some incidental sacrifice of sources or facts needed in the administration of justice".[3]

2.06 The categories of privilege were initially determined by the common law's view of what best served the state's interest in the proper administration of justice.[4] Historically they are of limited number, and have been narrowly construed because they have an obstructive effect on the trial process and constitute an exception to the court's demand for every person's evidence. The court's need for all material evidence to be presented

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[3] McCormick's Handbook of the Law of Evidence (2d ed. E.W. Cleary) 1972, at 152.

[4] D. Vaver, "Medical Privilege in New Zealand" (1969), 1 Auckland U.L. Rev. 63, at 66.

is clearly stated by Lord Sumner in Russell v. Russell:

> . . . [I]n the administration of justice nothing is of higher importance than that all relevant evidence should be admissible and should be heard by the tribunal charged with deciding according to the truth. To ordain that a Court should decide upon the relevant facts and at the same time that it should not hear some of those relevant facts from the person, who best knows them and can prove them at first hand, seems to me to be a contradiction in terms. It is best that truth should out and that truth should prevail.[5]

2.07 Privileged communications take various forms and are protected from disclosure for different policy reasons. They can be categorized as follows:

1. Those types of privilege which have as their focus the protection of the rights of the individual. The important privilege falling within this group is the privilege against self-incrimination founded on the common law, as altered by statute.[6]

2. Those types of privilege designed to protect the integrity of government fall under the broad heading of Crown privilege. They include the privilege respecting affairs of state, the police informant privilege, and the privilege respecting parliamentary proceedings.

3. The privilege which gives limited protection to "without prejudice" statements made during the course of settlement negotiations. The purpose of the privilege is to encourage parties to resolve their private disputes without resort to litigation. Without this protection, frank discussion between the parties would often be impossible.

4. Those types of privilege concerned with confidential communications made within certain special relationships. Included within this category are the solicitor-client privilege, the privilege protecting communications between husband and wife,[7] and in some jurisdictions, the priest-

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[5][1924] A.C. 687, at 748.

[6]"The Manitoba Evidence Act", C.C.S.M. c. E150, s. 7; Canada Evidence Act, R.S.C. 1970, c. E-10, s. 5; Canadian Charter of Rights and Freedoms, s. 11(c) and s. 13.

[7]"The Manitoba Evidence Act", C.C.S.M. c. E150, s. 10; Canada Evidence Act, R.S.C. 1970, c. E-10, s. 4(3).

penitent privilege[8] and the physician-patient privilege.[9]

This Report is concerned with confidential communications within the ambit of the fourth category.

2.08 Often cited as an explanation for the existence of privilege within the fourth category are the criteria stated by Wigmore,[10] the American authority on evidence. Wigmore says that four criteria are recognized as necessary to the establishment of a privilege against the disclosure of confidential communications within a given relationship:

1. The communications must originate in a confidence that they will not be disclosed.

2. This element of confidentiality must be essential to the full and satisfactory maintenance of the relationship between the parties.

3. The relationship must be one which in the opinion of the community ought to be sedulously fostered.

4. The injury that would inure to the relationship by the disclosure of the communication must be greater than the benefit thereby gained for the correct disposal of litigation.

These four criteria are often referred to in discussions of privilege, and the vast majority of legal commentators see them as useful guidelines in resolving

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[8]In Canada, the Provinces of Quebec and Newfoundland have enacted such a privilege: "Quebec Civil Code", 1965, Vol. 2, s. 308 as am. "Charter of Rights and Freedoms", R.S.Q. 1977, c. C-12, s. 9; "The Newfoundland Evidence Act", R.S.N. 1970, c. 115, s. 6.

[9]In Canada, only Quebec has enacted a physician-patient privilege: "Quebec Civil Code", 1965, Vol. 2, s. 308 as am. "Charter of Rights and Freedoms", R.S.Q. 1977, c. C-12, s. 9.

[10]Wigmore, Evidence (McNaughton Rev.), 1961, Vol. 8, at 527, para. 2285.

the question of a particular claim for privilege. They have been applied as an explanation for those categories of privilege already existing at common law, and as a test for the creation of new ones.

2.09 Wigmore's fourth criterion (and the one most often commented upon) highlights the fact that the courts are involved in balancing values when they consider claims of privilege. On the one hand is society's desire to protect the confidentiality which is vital to the functioning of certain relationships; on the other, is the importance of ensuring that justice is served by placing before the courts all of the relevant evidence. It has been said that a resolution of this conflict often involves the courts in "a comparison of value judgments which are not commensurable".[11]

2.10 The difficulty the courts face in weighing conflicting values is especially apparent in respect of the physician-patient relationship. Is confidentiality within that relationship of such importance that it justifies the suppression of relevant evidence? The courts' answer to this question will be considered in Chapter 3. Their answer (like their answer to the claims of other professionals) reflects their dislike of all categories of privilege because of the evidentiary problems that they create. The courts have, however, recognized that the law must continue to adjust itself to society's needs; they have therefore declared that the categories of privilege are not closed.[12]

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[11]D.W. Louisell and K. Sinclair, Jr., "The Supreme Court of California 1969-1970: Reflections on the Law of Privileged Communications - The Psychotherapist-Patient Privilege in Perspective" (1971), 59 Calif. L. Rev. 30, at 55.

[12]Slavutych v. Baker, supra n. 2; Solicitor-General of Canada v. Royal Commission of Inquiry into Confidentality of Health Records in Ontario (1981), 128 D.L.R. (3d) 193 (S.C.C.) per Laskin, J. at 207; Reference Re Legislative Privilege (1978), 83 D.L.R. (3d) 161, 18 O.R. (2d) 539 (Ont. C.A.).

B. The Policy Underlying a Medical Privilege

2.11 Having considered privilege within the evidentiary framework, we turn now to examine the claim sometimes made that the law should recognize a medical privilege. The term "medical privilege" is intended to describe the rights, if any, a person consulting a physician has to insist on withholding from a court confidential information which might be relevant to a fact in issue. In this part of the Report we analyze the reasons most often advanced in support of such a privilege; they have typically found favour with legislators in the many United States jurisdictions where a medical privilege is in force. The special function performed by the psychiatrist, both in the medical field and in the courtroom, will be considered at para. 2.23 and following. The present analysis is directed to the orthodox medical privilege which would protect all physicians and their patients.

2.12 It is appropriate at the outset to refer to Wigmore's test and its application to the physician-patient relationship. Wigmore himself argued against a privilege for the physician-patient relationship. He was of the view that only the third of his four criteria was satisfied for physicians generally, ie. that the relationship was one which should be fostered. As to the other three criteria, he argues: (1) a person's ailments are in no real sense secret, for those which are not plainly visible are most certainly known to intimates; (2) even if disclosures to a physician were confidential they would be made regardless of whether a privilege attaches, for few people, if any, would refrain from seeking medical care because of a fear that something might later be disclosed in a courtroom; and (4) the injury to the cause of justice generally exceeds the injury to the relationship, for in many cases the courts will be denied information which may be known to others but which the privilege would keep from a court.[13]

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[13] Supra n. 10, at 829-30, para. 2380a.

2.13 With Wigmore's criteria, and opinions, as a reference point, we turn now to consider the arguments made by those who favour a general medical privilege.

1. Conflict with the physician's ethical duty of silence

2.13.1 The reason most forcefully advanced by physicians in favour of a medical privilege is connected with the Hippocratic Oath, by which physicians hold themselves duty-bound to keep secret the confidential information obtained from patients:

> Whatever, in connection with my professional practice, or not in connection with it, I see or hear in the life of man, which ought not to be spoken of abroad, I will not divulge, as a reckoning that all such should be kept secret.

To the same effect is the modern version of the rule contained in the Code of Ethics of the Canadian Medical Association:

> An ethical physician will keep in confidence information derived from his patient, or from a colleague, regarding a patient and divulge it only with the permission of the patient except when the law requires him to do so.

2.13.2 Most physicians see the physician's obligation to give expert testimony in a court of law (in circumstances where their patient's consent is withheld) as conflicting with what they understand to be the demands of their professional ethic. For this reason, they argue that a privilege should be recognized.

2.13.3 Here we make two observations. The first is that when we speak of the physician's ethical duty of silence we are referring to the broad concept of confidentiality which is usually assumed by the public to be a part of any professional relationship. With respect to the medical profession, this belief is reflected in the professional Code of Ethics. Thus, a physician who breaches the Code by revealing a patient's confidences to a third party is likely subject to disciplinary action by his governing professional body.[14] The law, too, supports the public's belief in professional confidentiality: a physician who does not keep a patient's secrets may be liable in a civil action for breach of contract or breach of confidence.[15] The law, however, draws a distinction between "confidential" and "privileged" communications. Confidential communication refers to information the physician obtains from a patient while acting in a professional capacity. A privileged communication, on the other hand, refers to the very special situation where confidential information is protected from disclosure in a court of law. It is with the broad concept of confidentiality with which the ethical code is essentially concerned, and not the much narrower, although related, issue of privilege.

2.13.4 Second, neither the Hippocratic Oath nor the Code of Ethics prescribes an absolute duty to keep confidential information secret. Both definitions specifically admit to the propriety of divulging information

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[14]See G. Sharpe and G. Sawyer, Doctors and the Law, 1978, at 95.

[15]Halls v. Mitchell, [1928] S.C.R. 125; A.B. v. C.D. (1851), 14 Suss. Cas. 177 (Scot. Ct. of Sess.). See D. Gibson, "Common Law Protection of Privacy - What To Do Until the Legislators Arrive", L.N. Klar (ed.), Studies in Canadian Tort Law, 1977, Ch. 12, 363-364, S. Freedman, "Medical Privilege" (1954), 32 Can.B.Rev. 1, at 11-13, and for a discussion of English law and recommendations for reform, see England, The Law Commission, Breach of Confidence, Cmnd. 8388 (1981).

in situations where it "ought" to be disclosed, or where the "law requires" disclosure. Examples of the physician's legal obligation to reveal confidential information abound. For example, physicians in Manitoba are required to report cases of infectious and contagious disease,[16] file certificates of birth,[17] certify causes of death,[18] report cases of suspected child abuse,[19] and report the names of patients suffering from conditions that may make the driving of a motor vehicle dangerous.[20] Yet it has not been seriously suggested that a physician violates his oath when he observes these duties.

2.13.5 If medical privilege is thought to be justified on the basis of ethical duty alone, a similar claim for privilege could be made by other professional groups. The public confidence in the judicial process would be seriously undermined if privilege were to be so extended. We are in agreement with the remarks of the Ontario Royal Commission Inquiry into Civil Rights, that:

> . . . [T]he law cannot recognize any power in professional bodies to impose on their members declarations of secrecy (if they do) which would override the right of the individual to a disclosure of the truth before a court of justice. This would be an invasion of civil rights which ought not to be tolerated.[21]

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[16] A Regulation Respecting Diseases and Dead Bodies Under The Public Health Act, Man. Rev. Reg. 1971, P210-R2.

[17] "The Vital Statistics Act, C.C.S.M. c. V60, s. 3.

[18] "The Vital Statistics Act", C.C.S.M. c. V60, s. 14(3).

[19] "The Child Welfare Act", C.C.S.M. c. C80, s. 36(3).

[20] "The Highway Traffic Act", C.C.S.M. c. H60, s. 150.1(1).

[21] Ontario Royal Commission Inquiry into Civil Rights (1968), Report #1, Vol. 2, 823 (J.C. McRuer).

2. The solicitor-client analogy

2.13.6 Another argument often relied upon by advocates of a medical privilege is based on an assumed analogy between the roles of lawyers and physicians. It is argued that the ethic of both professions is one which requires secrecy, and accordingly the law should respect the professional secrecy of the physician, in the same manner and to the same degree, as it does the professional secrecy of the lawyer.

2.13.7 There is, however, a fundamental difference between the physician-patient relationship and that which exists between solicitor and client. It is not primarily because the lawyer's work is confidential that solicitor-client privilege arises, but rather because the client consulting a lawyer frequently does so in contemplation of the possibility of litigation.[22] For a lawyer to represent his client properly, that client must be able to divulge all facts, whether adverse or not, to his counsel, without fear that the lawyer could later be compelled to divulge those facts in a court of law.

2.13.8 Lord Brougham explained the rationale for the solicitor-client privilege in this often quoted passage from Greenough v. Gaskell:

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[22]For a modern statement of the scope of solicitor-client privilege, see Descoteaux v. Mierzwinski and A.-G. Que., [1982] 1 S.C.R. 862, 141 D.L.R. (3d) 590, 70 C.C.C. (2d) 385 (S.C.C.).

> The foundation of this rule is not difficult to discover. . . . [I]t is out of regard to the interests of justice, which cannot be upholden, and to the administration of justice, which cannot go on, without the aid of men skilled in jurisprudence, in the practice of the Courts, and in those matters affecting rights and obligations which form the subject of all judicial proceedings. If the privilege did not exist at all, everyone would be thrown upon his own legal resources; deprived of all professional assistance, a man would not venture to consult any skilled person, or would only dare to tell his counsellor half his case.[23]

2.13.9 The policy justification for the solicitor-client privilege thus has to do not with confidentiality as such, but with the basic right of individuals to prosecute actions and prepare defences in order to preserve the proper administration of the law. Such a justification is not relevant to a claim for medical privilege. A patient consulting a physician does so with his thoughts centred on his illness and not on the possibility of legal proceedings. A privilege will not encourage him to confide in his physician because the thought of his physician's subsequently divulging his confidences in court is not present in his mind at the time of consultation. In our judicial system, the lawyer is as indispensable as the judge or jury. To deny a privilege for communications to legal advisors is to interfere with the administration of justice. In contrast, to deny a privilege for communications made to physicians may, in the words of one commentator, "have unfortunate effects upon its social image, may be very unfair, even prejudicial to the [patient's] interest, but does not interfere per se with the administration of justice itself".[24]

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[23](1833), 1 My. & K. 98 (Ch.), at 103, 39 E.R. 618, at 620-21.

[24]The Law Reform Commission of Canada Evidence Study Paper (1975), 12 Professional Privileges Before the Courts, 8.

2.13.10 In the final analysis, the claim for a medical privilege must be judged on its own merits, and not in relation to another profession which performs a very different public function.

3. The promotion of public health

2.13.11 The primary rationale of a medical privilege is to aid in the effective treatment of injury and disease by encouraging patients to make full disclosure to their physicians. The theory is that, in the absence of a medical privilege, persons suffering from serious illness may hesitate to confide in a physician because of the embarrassment and shame that would result were the physician ever required to divulge the patient's confidences in a courtroom. The privilege is designed to promote the public health and welfare by assuring the patient confidentiality.

2.13.12 This theory is based on a questionable assumption. It assumes that a prospective patient will be knowledgeable about the privilege and the protection it affords, and will therefore speak more candidly. Yet commentators have said that in those United States jurisdictions which give a privilege to medical information, patients are for the most part unaware of its existence.[25] If patients are ignorant about the existence of a privilege, it can have no effect upon the degree to which they confide. Indeed, the Torts and General Law Reform Committee of New Zealand has recommended that the existing medical privilege in that jurisdiction not be extended because the Committee was "convinced that the

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[25]See C. DeWitt, Privileged Communications Between Physician and Patient (1958) at 34-35; M. O'Neill, "Ohio's Physician-Patient Privilege in Personal Injury Cases -- Time for Reform" (1965), 16 Case W. Res. L. Rev. 334, at 342; E. Cosden, "The Physician-Patient Privilege in Oklahoma" (1971), 7 Tulsa L.J. 157, at 172.

availability of a medical evidentiary privilege rarely makes any difference to a person's decision whether or not to seek medical help".[26]

2.13.13 It must be borne in mind, too, that there are relatively few ailments which would cause shame and disgrace to the sufferer if made public. Most injuries and diseases are attended with neither humiliation nor disgrace. In fact, their existence is rarely kept secret by the patient himself. Observed Wigmore: "Most of one's ailments are immediately disclosed and discussed. The few that are not openly visible are at least explained to intimates. No statistical reckoning is needed to prove this. These facts are well enough known".[27] There are of course some diseases which a patient may understandably want concealed. Venereal disease is an example. Physicians, however, are now required to report any real or suspected cases of venereal disease to public authorities, and the requirement of disclosure has not discouraged individuals from seeking treatment.[28] The fact that a small number of communications to a physician are embarrassing is not sufficient reason to suppress all communications.

2.13.14 The vast majority of encounters between physicians and patients are unrelated to litigation. For most patients, the possibility that some day a physician may be required to reveal confidential medical information is so remote that it is never even considered.

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[26]Professional Privilege in the Law of Evidence (1977), Appendix I: Report on Medical Privilege.

[27]Supra n. 10, at 829, para. 2380a.

[28]Telephone conversation with Dr. W. French, Executive Director, Medical Health Services, Manitoba Department of Health.

4. Community outrage and repugnance

2.13.15 It has been said that a fundamental justification of medical privilege is based on the theory of "community outrage and repugnance at having one's physician act against his patient's interests - especially in a manner which throws open a private relation to the scrutiny of all".[29] This argument is grounded on the view that the community must place certain limits upon its search for truth:[30] the state should seek to protect the individual's right to privacy and should be reluctant to participate in, or to foster, the breach of a private trust.

2.13.16 This argument acknowledges the betrayal felt by the patient whose physician reveals confidential information which the patient assumed would be kept secret. For the law to accede to the argument, however, would be tantamount to a declaration that confidentiality, in and of itself, justifies an evidentiary privilege. This the law has always refused to do. Courts have steadfastly maintained that there must be a public interest dimension beyond the merely "confidential".[31] In the words of Lord Diplock in a recent English decision:

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[29]Note, "The Physician-Patient Privilege" (1961), 56 Nw. U.L. Rev. 263, at 267.

[30]Ibid.

[31]Reference Re Legislative Privilege, supra n. 12; D. v. National Society for the Prevention of Cruelty to Children, [1978] A.C. 171, [1977] 1 All E.R. 589 (H.L.); Crompton (Alfred) Amusement Machines Ltd. v. Customs and Excise Commissioners (No. 2,), [1974] A.C. 405, [1973] 2 All E.R. 1169 (H.L.).

> The private promise of confidentiality must yield to the general public interest that in the administration of justice truth will out, unless by reason of the character of the information or the relationship of the recipient of the information to the informant, a more important public interest is served by protecting the information . . . from disclosure in a court of law.[32]

Wigmore's test also reflects the view that confidentiality is of itself insufficient to justify a privilege: his third and fourth criteria make it clear that communications must meet an additional "public interest" requirement.

2.14 We have now considered several of the policy justifications of a medical privilege. Each is in some way appealing, but we do not consider that either individually or as a whole they justify the creation of a new privilege within the evidentiary rules. Wigmore's judgment that his test was not satisfied in respect of the physician-patient relationship would appear to be confirmed. We are now in a position to consider the problems which can arise when physician-patient communications are protected despite the lack of a compelling policy justification.

C. The American Experience with Statutory Medical Privilege

2.15 Commenting in 1972 on the American experience with privilege, McCormick, a leading United States authority on evidence, noted that the development of common law or judge-made privilege had virtually halted a century earlier because of the judges' dislike for it.[33] Privilege survived in statutory form, however, as legislatures stepped in to protect rights of privacy which were generally seen as being "too important to relinquish to the

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[32] D. v. National Society for the Prevention of Cruelty to Children, supra n. 31, at 594 (All E.R.).

[33] Supra n. 3, at 156.

convenience of litigants".[34] In 1828, the New York Legislature enacted a physician-patient privilege,[35] and thereafter a majority of the states enacted similar statutes.[36] Most commonly, the statutory form found in American jurisdictions is different from the Law Reform Commission of Canada's recommendation which we have been asked to consider. The American medical privilege is usually of an absolute type which allows the presiding judge no discretion; the Law Reform Commission provision, on the other hand, would require the use of judicial discretion to balance the competing claims of privacy and public interest. Despite this distinction, the American experience serves to highlight the case against the enactment of a physician-patient privilege in Manitoba.

2.16 The policy underlying the various enactments in the United States is the same, yet there exists a wide disparity both in language and in substance. Most of the states grant a medical privilege to licensed physicians only, although some extend it to registered nurses and to physicians' stenographers or clerks. In some jurisdictions, the privilege is restricted to communications passing between a psychiatrist and his patient. The privilege operates only in civil actions in some states; in others, it may be invoked in both civil and criminal cases. Many states withhold the privilege in certain classes of actions. For example, in some states the protection may not be claimed when the patient or his personal representative has voluntarily placed in issue the patient's state of health, as in a personal injury action. Worker's compensation proceedings are frequently withdrawn from the operation of the statute, as are lunacy proceedings and will contests. An increasing number of jurisdictions prohibit invoking the privilege in cases of child neglect or abuse, in child custody cases and in other matters deemed to be of overriding public concern.

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[34] Id., at 157.

[35] II N.Y. Rev. Stats., pt. III, ch. 7, tit. 3, art. 8, s.73 (1829).

[36] See 8 Wigmore, supra n. 10, 1983 Pocket Supplement (W.A. Reiser, Jr.) 144, para. 2380.

2.17 In those American jurisdictions which have enacted a medical privilege there have been numerous cases of its abuse, with the result that courts and legal commentators have repeatedly challenged the justification for its existence. The two leading American authorities on the law of evidence, for instance, are both opposed to the privilege. Wigmore has described it as "merely a clever legerdemain, loaned by the law to the parties to suppress the truth";[37] he says that "[t]he adoption of it in any other jurisdictions is earnestly to be deprecated".[38] McCormick has observed that "[m]ore than a century of experience with the statutes has demonstrated that the privilege in the main operates not as a shield of privacy but as the protector of fraud. Consequently, the abandonment of the privilege seems the best solution".[39]

2.18 A brief consideration of American case law demonstrates some of the problems which have given rise to the call for abandonment of the privilege. In the United States it has been estimated that 90% of the litigation in which the medical privilege is invoked consists of the following three classes of cases:[40]

(1) actions on policies of life, accident or health insurance;

(2) actions for damages for personal injury or for wrongful death;

(3) testamentary actions where the mental competency of the testator is the principal issue.

2.19 In the majority of these cases, the testimony of the attending physician is usually the best and most reliable evidence. Yet when a privilege is in force the patient may, at his option, suppress his physician's

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[37]Wigmore, Evidence (3rd ed. 1940), Vol. 8, at 836, para. 2389.

[38]Supra n. 10, at 832, para. 2381.

[39]Supra n. 3, at 228.

[40]C. DeWitt, Privileged Communications Between Physician and Patient (1958), at 33; but note Wigmore, supra n. 10, at 831 says 99%.

testimony no matter how relevant it may be to the just disposition of the case. The result, according to a noted American author, is that the medical privilege has permitted unwarranted recovery on policies of insurance, fostered fraudulent claims in personal injury litigation, and excluded essential medical testimony in testamentary actions requiring the determination of mental capacity.[41] A summary of some of the American cases is illustrative:

> An action was brought to recover death benefits under a policy of accident insurance which specifically excluded recovery where a death was caused by asphyxiation by carbon monoxide. The deceased had been found lying in his garage with the motor of his car running. Two physicians were unsuccessful in attempts to revive him. At trial, the physicians testified that the deceased had shown characteristic signs of carbon monoxide asphyxiation, and the court ruled in favour of the defendant insurer. The plaintiff appealed on the ground that the physicians should not have been allowed to testify because of medical privilege. The higher court agreed, the evidence of the two physicians was excluded, and the plaintiff recovered under the policy of insurance.
> Palmer et al v. Order of the United Commercial Travelers of America[42]

> The insurer denied coverage under a policy of accident insurance on the basis that the deceased had died as a result of gall bladder disease, and not by accident. A physician who had performed an operation on the deceased prior to his death testified at trial that he believed the cause of death was due to an accident suffered by the deceased and not to disease. On appeal, the court held that the medical privilege statute barred the essential medical testimony and that the deceased's executor could not waive the privilege. The privilege operated to prevent recovery by the insured's beneficiaries.
> Main v. Maryland Casualty Co.[43]

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[41] Z. Chafee, "Privileged Communications: Is Justice Served or Obstructed by Closing the Doctor's Mouth on the Witness Stand?" (1943), 52 Yale L.J. 607.

[42] (1932), 245 N.W. 146 (Minn. S.C.).

[43] (1920), 178 N.W. 749 (Wis. S.C.).

> The defendant, who was also the attending physician, was not allowed to present X-rays of the plaintiff which would have shown the possibility that the plaintiff's injuries resulted from a previous accident and not from the defendant's negligence.
> Hudson v. Blanchard[44]

> The plaintiff sued the defendant building owner alleging he had negligently suspended a fire hose in such a way as to cause the plaintiff injury. The defendant alleged that the plantiff's poor health pre-dated the accident. The court refused to allow the testimony of a physician called by the defendant for the purpose of proving that the plaintiff had been ill prior to the accident, "in view of the very delicate and confidential nature of the relation".
> Harpman v. Devine[45]

2.20 Decisions such as these have led to both judicial and legislative attempts to restrict the scope of statutory medical privilege. The judicial efforts have given rise to hundreds of conflicting and confusing decisions,[46] and legislative attempts to prevent abuse have so seriously undercut the operation of the privilege that many statutes have been reduced to little practical value. As one leading writer has observed, "[t]he large number of exceptions now found in the more carefully drafted contemporary statutes raises doubt as to the scope and validity of what is left of the privilege".[47]

2.21 McCormick has summarized the harmful results of the privilege as follows:

> 1. The suppression of what is ordinarily the best source of proof, namely, the physician who examined and treated the patient, upon what is usually the crucial issue, namely, the physical or mental condition of the patient.

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[44](1956) 294 P. 2d 554 (Okla. S.C.).

[45](1937) 10 N.E. (2d) 776 at 779 (Ohio S.C.).

[46]Wigmore, supra n. 10, at 818-868 sets forth, by way of footnotes, hundreds of cases in which the courts have made contradictory decisions in respect of most of the important issues in the area.

[47]McCormick, supra n. 3, at 227.

2. The one-sided view of the facts upon which the court must act when it hears the story of the patient and some doctors selected by him but allows the patient to close the mouth of another doctor whom he has consulted, who would contradict them.

3. The complexities and perplexities which result from a statute which runs against the grain of justice, truth and fair dealing. These perplexities inevitably produce a spate of conflicting and confusing appellate decisions, and encrust the statutes with numerous amendments, reaching for but never attaining the reconciliation of the privilege with the needs of justice.[48]

2.22 We concluded earlier that there appears to be no compelling policy justification for a general medical privilege. That conclusion is borne out by the American experience with medical privilege: the types of cases in which it is usually claimed, and the courts' reaction to those claims, indicate that such a privilege, once enacted, is neither effective nor desirable. Our conclusion concerning a privilege in regard to communications between patients and physicians generally, therefore is as follows:

CONCLUSION 1

That there appears to be no compelling reason for the courts to recognize a privilege for communications between patients and physicians generally.

D. The Special Case of the Psychiatric Relationship

2.23 Because of the nature of the psychiatrist-patient relationship, a psychiatric privilege (as opposed to a privilege governing physicians generally) deserves special consideration. The question must be asked: is there such a significant distinction between communications made to physicians generally and those made to psychiatrists such that a psychiatric privilege can be justified even if a general medical privilege cannot?

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[48] Id., at 226.

2.24 Many legal commentators have suggested that such a distinction exists.[49] It is said to be based upon the fact that the very essence of the psychiatric relationship is confidentiality: without the assurance of secrecy, patients will not seek the help they need, and the public interest in the effective treatment of psychiatric patients will not be served. An English psychiatrist, who refused to testify in court about one of his patients, explained the need for confidentiality in this way:

> For me the need to retain secrecy was not just a moral imperative such as might exist, for example, for a general practitioner who was treating a patient for pneumonia. If such a doctor were to talk indiscreetly about his patient, he might not be behaving ethically, but he might still have treated the pneumonia adequately. But if I were to speak indiscreetly about a patient, I should not only be behaving unethically, but I should also be destroying the very fabric of my therapy. For people to be able to speak freely, and only then could I help them, I must supply a setting within which this could happen, and this setting was an essential part of the treatment.[50]

2.25 We have said with respect to physicians generally that confidentiality alone cannot justify an evidentiary privilege, and we considered Wigmore's test as a guide-post for determining what other factor(s) might be required. Is that test satisfied with respect to the psychiatric relationship?

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[49]A. Maloney, "Comments", D.N. Weisstub (ed.), Law and Psychiatry, 1977, 130; R.M. Fisher, "The Psychotherapeutic Professions and the Law of Privileged Communications" (1964), 10 Wayne L. Rev. 609; Louisell and Sinclair, supra n. 11; R. Slovenko, "Psychiatry and a Second Look at the Medical Privilege" (1960), 6 Wayne L. Rev. 175; R. Herst, "The Psychiatrist-Patient Privilege in Illinois" (1978-79), 10 Loyola U.L. Rev. 525.

[50][Dr. Hayman], The Lancet (England) Oct. 16, 1965, at 785-86, quoted in Schiff, S.A., Evidence in the Litigation Process, Vol. 2 (1978), 1012-13.

2.26 Communications must originate in a confidence that they will not be disclosed. It is the nature of the psychiatric relationship that the patient must reveal his most personal and private emotions if treatment is to be successful. The patient must feel free to discuss matters he would not normally discuss with close family members; indeed, many patients initially seek help because they do not want, or feel able, to reveal themselves to family and friends. Hence the comment by an American legal writer that the psychiatric relationship "depends for its success upon the creation of an atmosphere in which embarassing facts will be freed from conscious and unconscious censorship".[51]

2.27 Given that communications made within the psychiatric relationship are essentially of a confidential character, it is difficult to imagine that the patient seeking help does so except on the understanding that secrecy will be maintained. In our view, the first of Wigmore's criteria would appear to be met.

2.28 Confidentiality must be essential to the relationship. Medical professionals agree that successful psychotherapy depends completely on the patient's trust in his therapist. While a physical ailment can often be treated by a physician in whom the patient does not have trust, it is otherwise with mental illness. In an often-quoted remark respecting the psychiatric process, Freud said that "the whole undertaking is lost labour if a single concession is made to secrecy".[52] It is impossible for a sound relationship to be established or maintained when a psychiatric patient is not assured that his confidences will be respected.

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[51] Fisher, supra n. 49 at 620-21.

[52] 2 Collected Papers (London: Hogarth Press, 1956) at 346, n. 1.

2.29 Confidentiality can be said to be essential to the psychiatric relationship if the lack of it constitutes a substantial deterrence to patients. The following comment by an American author is illustrative:

> Those persons who need help most will often be those who have reason to be fearful of some sort of legal action. The mother with the unmanageable child who fears proceedings in juvenile court for removing the child from her custody and who is afraid to consult a social worker, the compulsive kleptomaniac who has had repeated suspended sentences or probation for his petty thefts who is afraid to visit a psychiatrist, the dissident married couple in the shadow of divorce proceedings who are afraid to make that last attempt at reconciliation by seeing a marriage counselor, the chronic recidivist in a correctional institution who is afraid to join in group therapy because of what the effect upon his future parole of his spontaneous disclosures might be -- these, and many more, can be cited as situations where the absence of confidentiality guaranteed by a psychotherapist's privilege will deter those in need from even seeking out the services of those who might be able to help them.[53]

The need for confidentiality in a psychotherapeutic relationship has also been judicially recognized in Canada. In G. v. G., for example, the court stressed the necessity of full disclosure between patient and psychiatrist:

> Most generally and fundamental to the practice of psychiatry is the fact that the patient seeking medical help must give a detailed picture of his past life. A full statement can only be obtained if the patient knows that what he has to say and hear will be of strict confidential nature.[54]

2.30 In our view, Wigmore's second criterion is also satisfied.

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[53]Fisher, supra n. 49, at 622-23.

[54][1964] 1 O.R. 361, at 365-66 (Ont. H.C.).

2.31 The psychiatric relationship must be one to be fostered sedulously. This criterion, the only one which Wigmore believed satisfied by the physician-patient relationship, is obviously also met with respect to the psychiatric relationship. The community has a vital interest in encouraging those needing psychiatric care to seek treatment.

2.32 The potential injury of disclosure must be greater than the benefit gained thereby. This criterion requires weighing the possible damage that disclosure would cause to the relationship against the possible benefit to the litigation process. It is the most difficult criterion to fulfil. Authorities generally agree, however, that the psychiatric relationship can be so damaged when a psychiatrist is compelled to testify in court, that the relationship itself would not likely survive: the patient would not be inclined to continue in therapy with the same or any other psychiatrist.[55] It has been said that "[t]his distrust of psychotherapy could work severe harm, not only to the individual relationship, but also to society in general, because it cuts off the mentally disturbed person, whom society has an interest in curing, from the only source of that cure".[56] Moreover, disclosure, if publicized, may adversely affect other psychotherapeutic relationships.

2.33 Proponents of psychiatric privilege also point out that psychiatry does not have the same factual orientation as the law, making the benefits to be gained by psychiatric testimony of questionable benefit. Professor R. Slovenko, a noted American authority on psychiatry and law, has said:

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[55]See R. Slovenko and G. Usdin, Psychotherapy, Confidentiality and Privileged Communication (1966) at 46; Fisher, supra n. 49, at 625-26; "A State Statute to Provide a Psychotherapist-Patient Privilege" (1966-67), 4 Harv. J. Leg. 307, at 312.

[56]"A State Statute to Provide a Psychotherapist-Patient Privilege", supra n. 55, at 312.

> Although absolutely necessary in treatment, data from free-association, or fantasies, or memories, are not reliable for use in court as they mostly represent the way the person experienced an event, and not how the event occurred. They are not 'facts.' Psychic reality is not the same thing as actual reality. . . . As the material revealed in psychotherapy does not deal with reality of the outer world, it would make poor, yet prejudicial, evidence. . . . By and large, the data is of no value in the realism of the court.[57]

2.34 No unequivocal statement can be made respecting this fourth criterion. In some (perhaps most) cases the criterion would be satisfied. In others, it would not. For example, in custody cases and juvenile proceedings where a child's well-being is at stake, justice would demand that privilege not be used to suppress relevant evidence.[58]

2.35 We conclude that Wigmore's four-fold test will not be satisfied, in all aspects, with respect to every psychiatrist-patient relationship. An analysis of the test (the fourth criterion in particular) suggests that a determination must be made on a case-by-case basis depending on the particular facts. In our view, judicial decisions respecting psychiatric testimony should be "situationally defined";[59] whenever the privilege is claimed, competing interests must be weighed by the court. Our conclusion concerning a privilege in regard to communications between patients and psychiatrists accordingly is as follows:

CONCLUSION 2

That it would be desirable for the courts to recognize a privilege for communications between patients and psychiatrists in appropriate cases.

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[57]Slovenko, supra n. 49, at 194.

[58]S.A. Tacon, "A Question of Privilege: Valid Protection or Obstruction of Justice?" (1979), O.H. L.J. 332, at 344.

[59]J. London, "Privacy in the Medical Context", D. Gibson (ed.), Aspects of Privacy Law, 1980, Ch. 9, at 292.

2.36 We wish to refer to one remaining consideration: if a privilege respecting the psychiatric relationship can in some cases be justified, can it not also be justified in respect of other health care professionals who perform a similar counselling role? Psychologists and psychiatric nurses, for example, (and even, on occasion, general physicians) perform a counselling function akin to psychiatrists, and in certain situations Wigmore's test would be satisfied with respect to them. It is our view that the courts should be responsive to the needs of such health care professionals and their patients in those cases where the Wigmore test is met. We conclude:

CONCLUSION 5

That it would be desirable for the courts to recognize a discretionary privilege in regard to communications between patients and other professionals when those professionals perform a counselling function similar to psychiatrists.

2.37 Having identified the areas in which medical privilege should be recognized, and those in which it should not, we turn now to consider to what extent the existing law reflects our conclusions.

CHAPTER 3

THE PRESENT LAW

3.01 The purpose of this Chapter is to examine both the statutory and common law of Manitoba respecting medical privilege. We look first at the provisions of "The Mental Health Act"[60] which contain a statutory form of psychiatric privilege. Second, we consider the common law in its historical perspective, and analyze the Canadian case law both before and after 1975, the year of the important Supreme Court judgment in Slavutych v. Baker.

A. Statutory Psychiatric Privilege: Section 26.2 of The Mental Health Act

3.02 "The Mental Health Act" was amended in 1980 to create for the first time in Manitoba a qualified psychiatrist-patient privilege in respect of patients or former patients of those psychiatric facilities designated under the Act.[61] Specifically, section 26.2 (a copy of which is reproduced in Appendix A) establishes a method to prevent the disclosure of clinical records notwithstanding that it may be required by subpoena or court order. The

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[60] C.C.S.M. c. M110.

[61] The following are designated facilities: Brandon Mental Health Centre, Selkirk Mental Health Centre, Eden Mental Health Centre, Health Sciences Centre (General), St.Boniface General Hospital, Misericordia General Hospital, Grace General Hospital, Victoria General Hospital, Seven Oaks General Hospital, one ward (2 beds) of the Psychiatric Unit at Deer Lodge Veterans' Hospital, one room (one bed) of the Thompson General Hospital.

patient's attending physician is given an opportunity to state in writing that, in his opinion, disclosure would likely result in harm to the treatment or recovery of the patient, or in mental or physicial injury to a third person. The subpoena or order requiring disclosure cannot be complied with until a hearing is conducted to allow the court before which the matter is in issue to consider the merits of the attending physician's protest. If the court is satisfied that the alleged harm or injury is likely to result, it is directed not to order disclosure unless it is satisfied that "to do so is essential in the interests of justice".[62]

3.03 The section also provides for a testimonial privilege which prevents the disclosure in court of any knowledge or information obtained in the course of assessing or treating patients of a psychiatric facility. The testimonial privilege is considerably broader than the privilege respecting the clinical record: no hearing is required to establish the likelihood of harm to the patient or a third party before the privilege attaches, nor does the judge have any overriding discretion to order disclosure in a proper case. At the conclusion of this Report we analyze whether the distinction drawn in s. 26.2 between the testimonial privilege and that respecting clinical records is appropriate.

3.04 Section 26.2 of "The Mental Health Act" is the only form of statutory medical privilege existing in Manitoba. Its important qualification is that it protects only those persons who are or have been patients of a designated psychiatric facility. The section has no application to the large number of patients treated outside such facilities.

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[62] s. 26.2(6).

B. The Common Law

3.05 We stated in Chapter 1 that the decision of the Supreme Court of Canada in Slavutych v. Baker[63] marked the beginning of a fundamental change in the law of privilege and its application to confidential communications in Canada. Prior to this case, the common law recognized as privileged, only those communications made within two relationships: solicitor-client and husband-wife. In cases regarding confidential communications falling outside of these established categories, the courts did not recognize a privilege.

3.06 Such was the case with communications made within the relationship of physician-patient. The law's denial of a privilege in regard to these communications was stated as early as 1776 in the decision of The Duchess of Kingston's Trial, where Lord Mansfield said:

> If a surgeon was voluntarily to reveal these secrets, to be sure he would be guilty of a breach of honour, and of great indiscretion; but to give that information in a court of justice, which by the law of the land he is bound to do, will never be imputed to him as any indiscretion whatever.[64]

This position was re-affirmed by Jessel, M.R. in the case of Wheeler v. Le Marchant[65] more than a hundred years later.

3.07 The rule compelling the disclosure of physician-patient communications applied in both civil and criminal proceedings, and the physician who refused to give evidence could be held in contempt. The privilege, however, belonged to the patient and not to the physician. Thus, the patient could not be required to give evidence, and were he to want his physician to testify he could waive the protection. In the event of such a waiver, the physician could not refuse to testify.

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[63] Supra n. 2

[64] The Duchess of Kingston's Trial (1776), 20 How. St. Tr. 355, at 573.

[65] (1881), L.R. 17 Ch. D. 675.

3.08 Although the direct recognition of a medical privilege continued to be denied, certain Canadian courts in the early 1960's began to question the desirability of compelling all physician-patient communications, even if those communications were relevant to a fact in issue. These doubts became manifest particularly in cases involving the compellability of communications made between patients and psychiatrists or other counsellors. In particular, in Dembie v. Dembie[66] the Ontario Supreme Court declined to compel testimony from the wife's psychiatrist who had been called as a witness by the husband's lawyer. The action was one for alimony, and presumably the psychiatrist was called to disclose whether the wife had made any statements to him which could be used as admissions of conduct which would disentitle her. The court held that it would not force the psychiatrist to breach the Hippocratic oath, because it could be "inimical to a fair trial to force a psychiatrist to disclose the things he has heard from a patient . . . ".[67]

3.09 The Dembie case was applied in the custody action of G. v. G.[68] where both spouses had consulted a marriage counsellor prior to separation and the wife had also consulted a psychiatrist. In an obiter comment, Landreville J. stressed the need for confidentiality in the psychiatric relationship:

> . . . [I]t is inimical to bring into Court conversations, discussions and advice exchanged and received by husband and wife during that last period of cohabitation.
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> . . . .
>
> Most generally and fundamental to the practice of psychiatry is the fact that the patient seeking medical help must give a detailed picture of his past life. A full statement can only be obtained if the patient knows that what he is to say and hear will be of strict confidential nature.[69]

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[66](1963) 21 R.F.L. 46 (Ont. S.C.).

[67]Id., at 50.

[68][1964] 1 O.R. 361 (H.C.).

[69]Id., at 364-66.

3.10 Neither of these cases, however, purported to create a privilege for physician-patient communications. It has been suggested that each can be seen as a liberal application of the privilege respecting communications made in furtherance of settlement.[70] Seen in this light, they follow a strong line of English cases which held that communications between spouses and a mediator, made with a view to reconciliation, must be considered to be made "without prejudice".[71] Both cases, however, as we have seen, contain statements regarding the importance of protecting the privacy of the patient-psychiatrist relationship. These statements led Sopinka and Lederman to conclude, in 1974, that a qualified privilege for psychiatric communications had gained a foothold in Canada.[72]

3.11 Other Canadian cases took the position that courts had a discretionary power to refuse the disclosure of relevant evidence. In Carter v. Carter,[73] Loukidelis J. refused to compel a physician to testify that one of the parties may have had a venereal disease. The decision was made not on the basis of a physician-patient privilege (which was specifically denied), but on the basis that it was in the public interest that the court exercise its "discretionary powers to exclude relevant evidence".[74]

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[70]See G.S. Sharpe, "Legislative Recognition of a Physician-Patient Privilege" (1975), 23 Chitty's L.J. 64, at 66.

[71]See McTaggart v. McTaggart, [1948] 2 All E.R. 754 (C.A.).; Mole v. Mole, [1950] 2 All E.R. 328 (C.A.); Theodoropoulas v. Theodoropoulas, [1963] 2 All E.R. 772.

[72]Sopinka and Lederman, The Law of Evidence in Civil Cases, 1974, at 207.

[73](1974), 6 O.R. (2d) 603; 53 D.L.R. (3d) 491 (Ont. S.C.).

[74]Id., at 494 (D.L.R.).

A similar ruling was made in Cronkwright v. Cronkwright[75] in regard to confidential communications made by a husband and wife to an Anglican clergyman. In the course of the hearing of a divorce petition, Wright J. ruled that although the communications were not privileged, they could nevertheless be excluded by the Court's exercise of its discretionary power.[76]

3.12 All of these cases were decided prior to the Supreme Court of Canada decision of R. v. Wray.[77] It was decided in that case that a trial judge had no discretion to exclude relevant and probative evidence on the ground that it was contrary to the interests of justice. This case involved the admissibility of an involuntary confession in a criminal trial and, consequently, its application in civil cases, particularly in respect of confidential communications, is uncertain. However, the prevailing view was that a trial judge had little, if any, discretion to excuse a witness from testifying on the ground that a confidential communication should be

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[75][1970] 3 O.R. 784, (1971), 14 D.L.R. (3d) 168 (Ont. H.C.).

[76]These cases can be viewed in light of a line of English cases which stand for the principle that the courts have a broad discretionary power to exclude from evidence non-privileged communications where public policy demands. See Attorney-General v. Mulholland, [1963] 1 All E.R. 767, (C.A.), and Attorney-General v. Clough, [1963] 1 All E.R. 420 (Q.B.). The Law Reform Committee of England concluded in 1967 that the discretionary authority in that country was strong enough to obviate the need for any statutory protection for confidential communications (England, Law Reform Committee, Sixteenth Report, Privilege in Civil Proceedings, Cmnd. 3472 (1967)). Note, however, that some doubt was cast on this conclusion in D. v. N.S.P.C.C., supra n. 31 where the House of Lords was equally divided on the question of whether a trial judge has a discretion to exclude relevant evidence in civil proceedings.

[77][1971] S.C.R. 272; 11 D.L.R. (3d) 673; [1970] 4 C.C.C. 1.

protected.[78]

3.13 Despite the limitations imposed on Canadian courts by R. v. Wray, two important discretionary powers survived, and remain good law. First, the trial judge has a discretion not to impose a penalty on a witness who refuses to reveal a confidential communication.[79] Second, the trial judge has the right to suggest to counsel that a witness should not be pressed to answer questions. In practice, counsel frequently accede to such requests.[80] The exercise of the court's "moral authority" in the trial process is explained by Lord Simon in a recent English case:

> . . . I think that the true position is that the judge may not only rule as a matter of law or practice on the admissibility of evidence, but can also exercise a considerable moral authority on the course of a trial. For example, in the situations envisaged the judge is likely to say to counsel: You see that the witness feels that he ought not in conscience to answer that question. Do you really press it in the circumstances? Such moral pressure will vary according to the circumstances - on the one hand, the relevance of the evidence; on the other, the nature of the ethical or professional inhibition.

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[78] See Sopinka and Lederman, supra n. 72, at 218; B. McLachlin, "Confidential Communications and the Law of Privilege" (1977), 11 U.B.C. Law R. 266, at 271; J. Arvay, "Slavutych v. Baker: Privilege, Confidence and Illegally Obtained Evidence" (1977), 15 O.H.L.J. 456, at 471, n. 74.

[79] Reference re Legislative Privilege, supra n. 12, at 173 (D.L.R.); Dembie v. Dembie, supra n. 66.

[80] In Reference re Legislative Privilege, supra n. 12, at 172 (D.L.R.), Lacourciere J.A. said: "In Ontario, the Judge's suggestion that such questions not be pressed has generally been accepted: Cronkwright v. Cronkwright (1970), 14 D.L.R. (3d) 168, [1970] 3 O.R. 784, 2 R.F.L. 241".

> Often indeed such a witness will merely require a little gentle guidance from the judge to overcome his reluctance. I have never myself known this procedure to fail to resolve the situations acceptably. But it is far from the exercise of a formal discretion.[81]

3.14 It was not until the decision of Slavutych v. Baker that the issue of compelling the disclosure of confidential communications was resolved by the direct expansion of the doctrine of privilege. In that case, the Supreme Court of Canada considered a claim of privilege, not in terms of the established categories, but by using a flexible and policy-oriented approach. In doing so, it relied on the Wigmore test. Although Slavutych v. Baker deals with a different professional relationship than that of physician-patient, its policy orientation makes it applicable to a broad range of relationships, of which the physician-patient relationship is one.

3.15 The facts of the case are as follows. The University of Alberta, in considering whether to grant tenure to a colleague of Professor Slavutych, asked Slavutych to complete a confidential assessment of the colleague. Prof. Slavutych completed an assessment which contained derogatory remarks about the colleague. On the basis of these remarks the University fired Prof. Slavutych. The matter was referred to an arbitration board which agreed that the University had cause to dismiss Prof. Slavutych. The Appellate Division of the Alberta Supreme Court affirmed the decision of the arbitration board, although on different grounds. However, on appeal to the Supreme Court of Canada, Mr. Justice Spence, for the court, quashed the arbitration board's decision and held that the tenure assessment was not admissible in evidence in the arbitration proceeding, and could not be used as a basis for a charge of misconduct justifying dismissal.

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[81] D. v. National Society for the Prevention of Cruelty to Children, supra n. 31, at 613 (All E.R.).

3.16 The Supreme Court's decision was based on two grounds. The first was its conclusion that the University should not be allowed to use a document against its maker when it had induced him to complete it in the first place by a promise of confidentiality. This rationale was, in effect, an application of the equitable doctrine of confidence.[82] The second ground (one which may be considered as obiter dicta[83]) was the Court's finding that the document itself was privileged. In so holding, the Court accepted the plaintiff's argument that the types of communications to which a privilege will be granted have not been settled once and for all, and that in determining what confidences should be privileged, it was appropriate to consider them in the context of Wigmore's test.

3.17 The case is important in that, for the first time, in determining a claim to privilege, the Supreme Court adopted a flexible approach based on policy considerations. Commentators agree, however, that the case's importance

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[82]The basis for the equitable doctrine of confidence is the general duty to act in good faith. Lord Denning said in Seager v. Copydex, [1967] 1 W.L.R. 923, at 931 that the court's jurisdiction "does not depend on any implied contract. It depends on the broad principle of equity that he who has received information in confidence shall not take unfair advantage of it. He must not make use of it to the prejudice of him who gave it without obtaining his consent".

For a discussion of the Supreme Court's use of the doctrine of confidence see Arvay, supra n. 78.

[83]Spence J. regarded the doctrine of privilege as appropriate, but concluded that the case was "not to be considered as a matter of the application of the doctrine of privilege". He went on to discuss the doctrine of confidence. Supra n. 2 at 229 (D.L.R.).

may be limited by the fact that the finding of privilege was obiter,[84] and by the Court's less than careful application of Wigmore's test. With respect to Wigmore's test, Professor Arvay,[85] for example, points out that only the first two of the criteria were clearly applicable to the situation in Slavutych, ie. that the communication originated in a confidence, and the element of confidentiality was essential to the relationship between the parties. With respect to the third criterion, that the relationship be one which the community ought to foster sedulously, Prof. Arvay says that the common law has never recognized the employer-employee relationship as being of such importance as to attract a privilege, and that no compelling reason exists for considering the relationship in this case any differently than all other employer-employee relationships. He submits that the Court's analysis of the fourth criterion is faulty: there was no indication how the Court determined that disclosure would cause injury to the faculty-administration relationship more grave than the harm likely to result to the public interest in the administration of justice were relevant evidence excluded. Arvay concludes that the elevation of the relationship in this case was unwarranted.

3.18 Although the doctrine of privilege may not have been properly applied in Slavutych, the Supreme Court has nevertheless implied that evidentiary privilege may now cover confidential communications within relationships other than those formerly protected. Claims to privilege may be considered in light of Wigmore's test, by which future courts have been provided "a practical and rational guideline".[86]

3.19 The real significance of the case depends upon its application in subsequent decisions of Canadian courts. With few exceptions, courts have

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[84]See McLachlin, supra n. 78, at 273; H.J. Glasbeek, "Limitations on the Action of Breach of Confidence", D. Gibson (ed.), Aspects of Privacy Law, 1980, Ch. 8, at 278.

[85]Arvay, supra n. 78, at 466-468.

[86]Id., at 471.

accepted that Slavutych has fundamentally altered the rules respecting privilege; Wigmore's criteria are now generally applied. One of the first cases in which the Slavutych decision was applied was Strass v. Goldsack in which Clement J.A. said:

> . . . [T]he sanction given to these four conditions as the test for a claim of privilege provides a most useful and helpful rationale which should serve well the general public interest in determining such claims. Not only does it provide a rationale: it also leaves room by the third and fourth conditions for adaptation of the principle to changing needs and conditions of society which is essential to the proper function of the common law.[87]

3.20 Since Strass v. Goldsack, Wigmore's criteria have been applied to test claims of privilege in a variety of circumstances. In some cases, the test has been used to grant a privilege in situations where none had previously existed. For example, it has been used to grant a privilege in respect of personnel files of an employer under investigation by a provincial Human Rights Commission,[88] to protect from disclosure documents relating to the investigation of a physician by a hospital credentials committee,[89] and to protect from disclosure to an arbitrator confidential evaluations of a professor denied promotion.[90] The Wigmore test has also been used to deny claims of privilege. In Reference Re Legislative Privilege[91] the Ontario

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[87][1975] 6 W.W.R. 155 at 160, (1976), 58 D.L.R. (3d) 397 (Alta. S.C., A.D.). The issue before the Court was whether solicitor-client privilege attached to a written statement obtained from the plaintiff by an adjuster employed by the defendant's insurer, joined as a third party. The five member court, McGillivray C.J.A., dissenting, held that the statement was not privileged. For a discussion of the court's application of the Wigmore test, see S.N. Lederman, "Comment" (1976), 54 Can.B.Rev. 422.

[88]Re Alberta Human Rights Commission and Alberta Blue Cross Plan (1981), 128 D.L.R. (3d) 122 (Alta. Q.B.).

[89]Smith et al v. Royal Columbian Hospital et al (1981), 123 D.L.R. (3d) 723 (B.C.S.C.).

[90]Re University of Guelph and Canadian Association of University Teachers et al (1980), 29 O.R. (2d) 312 (H.C.).

[91]Supra n. 12.

Court of Appeal used the test to deny a claim made by a member of the legislative assembly in respect of information communicated to him by an informer. The test has also been used to deny privilege in respect of a "daybook diary" prepared by a plaintiff in a personal injury action,[92] in respect of contracts made between a meat producer and a marketing board,[93] and in respect of a report prepared by an investigating committee of a College of Dental Surgeons in a malpractice action against a dentist.[94]

3.21 The Supreme Court has also recently had an opportunity to comment on Slavutych. In Solicitor-General of Canada v. Royal Commission of Inquiry into Confidentiality of Health Records in Ontario[95] the majority decision does not refer to Wigmore's test because of a finding that the facts of the case called into play the police informant privilege.[96] However, Laskin J., in dissent, said this:

> What Slavutych v. Baker . . . established is that the categories of privilege are not closed . . . . This Court, speaking through Spence J. in the Slavutych case, was of the opinion that the four-fold test propounded in 8 Wigmore Evidence s. 2285, p. 527 (McNaughton rev. 1961), provided a satisfactory guide for the recognition of a claim of privilege.[97]

3.22 The effect of the Slavutych decision on claims of medical privilege is not yet known. In only one reported case since Slavutych has Wigmore's test

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[92]Jones v. Crompton and Hazlett, [1977] 4 W.W.R. 440 (B.C.S.C.).

[93]Swift Canadian Co. Ltd. v. Alberta Hog Producers' Marketing Board et al; Canada Packers Limited v. Alberta Hog Producers' Marketing Board et al (1979), 9 Alta. L.R. (2d) 107 (Dist. Crt.).

[94]Bergwitz v. Fast, (1980) 108 D.L.R. (3d) 732 (B.C.C.A.).; rev'g (1979), 97 D.L.R. (3d) 65 (B.C.S.C.).

[95][1981] 2 S.C.R. 494, (1982), 128 D.L.R. (3d) 193.

[96]This privilege was discussed in para. 2.07 of the Report and falls within the broader type of privilege pertaining to those designed to protect the integrity of government.

[97]Id., at 207 (D.L.R.).

been applied to the physician-patient relationship. In Re S.A.S.,[98] Wang J. of the Ontario Provincial Court (Family Division) held that a wife's psychiatrist was a compellable witness in a custody dispute. Wigmore's test was applied (as were also the cases of Dembie and G. v. G.) and the judge determined that because the welfare of a child was involved, Wigmore's fourth criterion was not satisfied. The Slavutych decision was not specifically referred to, and it is not clear whether Wang J. was aware of this decision.

3.23 Two factors make it difficult to make a conclusive statement about the law respecting medical privilege post Slavutych v. Baker: the first is the lack of case law, and the second is the situational nature of the Wigmore test itself whereby the validity of a claim for privilege is dependent on the facts of a particular case. Some conclusions, however, can be drawn. From our policy analysis of Wigmore's criteria vis-a-vis the general physician and the psychiatrist, we have seen that ordinarily the test is satisfied only with respect to the psychiatric relationship. The pre-1975 case law indicates, too, that, even without the benefits of Wigmore's test, courts seek to protect the psychiatric, and not the general medical, relationship. The Slavutych case will not cause a fundamental change in the law's regard for claims of medical privilege; it has, however, provided the courts with a basis for determining such claims without necessitating the exercise of a broad, and questionable, discretion.

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[98](1977), 1 Legal Medical Qtly. 139 (Ont. H.C.).

CHAPTER 4

IS STATUTORY REFORM NECESSARY?

4.01 We have now identified those medical relationships which we believe the law should seek to protect through evidentiary privilege. We have also examined the way in which the law has responded to the claims of medical professionals that confidential communications be privileged. We are now in a position to determine whether statutory reform is necessary. Specifically, we must consider whether Manitoba's Evidence Act should be amended to include s. 41 of the Law Reform Commission of Canada's Report on Evidence. We intend first to examine the protection given to medical relationships by the common law and then to consider whether the enactment of s. 41 would represent an improvement. The protection afforded to psychiatric patients by s. 26.2(8) must also be considered.

4.02 The common law's response to the concern for confidentiality within medical relationships would now appear to be the Wigmore test; we must therefore begin with an analysis of the adequacy of the test itself. At the outset, it must be acknowledged that Wigmore's test is flawed by its ambiguous language. For instance, does "injury to the relation" mean injury to a particular relationship or to all such relationships? By what standard is the benefit to be measured and how is it to be weighed against the injury? The difficulty which this ambiguity can cause is an expansion of privilege generally; arguably, use of the test could undermine long-standing evidentiary principles.[99] Certainly in Slavutych v. Baker itself, the ambiguous wording of the test caused the Court problems of application. We have seen, however,

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[99]For a critique of the Wigmore test, see Note, "Functional Overlap Between the Lawyer and Other Professionals: Its Implications for the Privileged Communications Doctrine" (1962), 71 Yale L.J. 1226, at 1230. See also Glasbeek, supra n. 84, at 277-279.

from subsequent judicial decisions, that the courts' natural reluctance to exclude relevant evidence has ensured a generally moderate application of the test.

4.03 We believe the Wigmore test to have a number of positive features:

1. It recognizes that problems in this area of the law are situationally defined; whether a privilege for physicians will be granted in any given case will depend on the particular facts.

2. By providing the courts with principled criteria to apply to particular fact situations, they are relieved of the burden of a too-broad discretion, the exercise of which can result in great uncertainty within the rules of evidence. Wigmore's criteria place reasonable limits on the exercise of the courts' discretionary power.

3. The test obviates the need for identifying particular professional relationships as requiring a privilege; rather, its approach is a functional one that focuses on the nature of the relationship and the particular confidence involved. The inflexible categories of the pre-1975 common law have given way to a test which is broad enough to protect a wide range of relationships, arguably even those which are not strictly professional in nature. This is of some importance in the medical field where the law should be able to respond, in particular cases, to the needs of persons involved in therapeutic relationships with professionals such as psychologists and psychiatric nurses.

4.04 It is our view, therefore, that the Wigmore test is sensible and workable. Proper application of it will safeguard the psychiatrist-patient relationship without at the same time providing an unwarranted protection to the general medical relationship. Accordingly, we conclude:

CONCLUSION 4

That the Wigmore test, adopted by courts to determine the recognition of privilege for confidential communications generally, provides an appropriate basis for the determination of claims to privilege within the medical field.

4.05 We turn now to consider s. 41 of the Law Reform Commission of Canada Report. Like the Wigmore test, s. 41 is general. It does not specify what types of communications within what relationships should be granted a privilege; instead, it takes a principled approach based on the nature of the relationship and the type of communication involved. This approach allows the law to be flexible enough to deal with a broad range of relationships. There is, however, an important distinction between s. 41 and the Wigmore test. That is, section 41 is positive in nature while the Wigmore test is essentially negative. S. 41 would grant a privilege to all professionals unless the public interest demanded disclosure. In contrast, under the Wigmore test admissibility is presumed, and no privilege is granted except in cases where the four criteria are met.

4.06 We are not persuaded that s. 41 is the correct approach. We do not think that the law should presume a privilege, even of a discretionary type, for physicians generally. With regard to the psychiatric relationship, we appreciate that s. 41 would give psychiatrists and their patients, at the outset, a measure of reassurance as to confidentiality. However, as under the Wigmore test, whether a privilege would be granted in any given case would still depend on the court's interpretation of "the public interest". It is our view that as a body of case law develops interpreting the Wigmore test, psychiatrists and their patients will be granted sufficient protection without, as does s. 41, necessitating a presumption of privilege for a broad class of unspecified "person[s] exercising a profession".

4.07 We believe that in order to ensure that there will not be a proliferation of new, and questionable, privilege, the better approach is one which begins with an assumption that all evidence is admissible. That approach is the Wigmore test.

4.08 In our view, the common law respecting evidentiary privilege has shown itself capable of adjusting itself to society's changing needs, and

that, consequently, statutory reform is undesirable. This view is shared by the Federal Provincial Task Force on Uniform Rules of Evidence[100] which has recently concluded that there is no need for statutory change because of the developing nature of the common law. With respect to medical relationships, the direction taken by the law is such that protection will be granted where, on balance, the public interest would benefit from non-disclosure of particular communications. Accordingly, we conclude:

CONCLUSION 5

That "The Manitoba Evidence Act" should not be amended to create a presumption that communications between patients and physicians generally are privileged, as contemplated by s. 41 of the Law Reform Commission of Canada's **Report on Evidence** with respect to federal legislation.

4.09 One further consideration remains. In paragraphs 3.02-3.04 of this Report we referred to the statutory psychiatric privilege established by s. 26.2 of "The Mental Health Act". That section creates two forms of privilege in respect of patients or former patients of designated psychiatric facilities: one in respect of clinical records, and the other a testimonial privilege created by s. 26.2(8). Unlike the privilege respecting clinical records, the testimonial privilege appears to be absolute: the court has no overriding discretion to order disclosure where the interests of justice warrant it in a given case.

4.10 S. 26.2(8) is patterned after a similar section in the Ontario Mental Health Act (a copy of which is reproduced in Appendix B). The Ontario provision, however, contains a further clause, one not included in the Manitoba section, which provides that the court has a discretion to order disclosure if it determines that the disclosure "is essential in the interests of justice".[101] Such a determination can be made only after a hearing from

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[100] Canada, Report of the Federal/Provincial Task Force on Uniform Rules of Evidence (1982), 419-22.

[101] Mental Health Act, R.S.O. 1980, c. 262, s. 29(9).

which the public is excluded, held on notice to the patient.

4.11 In our view, the courts' inability to exercise an overriding discretion under s. 26.2(8) creates an anomaly within the scheme of s. 26.2. We can see no reason for allowing the court a discretion to order disclosure with respect to clinical records, and not with respect to testimony. From our examination of the American experience with non-discretionary privilege, we concluded that a form of non-discretionary privilege can lead to injustice and is neither effective nor desirable. Accordingly, we do not believe that the interests of justice would be properly served by the granting of an absolute privilege to patients treated in designated facilities. We conclude:

CONCLUSION 6

That s. 26.2(8) of "The Mental Health Act" should be amended by the addition of the following clause:

(c) where the court, or, in the case of a proceeding not before a court, the Court of Queen's Bench determines, after a hearing from which the public is excluded and that is held on notice to the patient, or (where the patient has not attained the age of majority or is not mentally competent) the Public Trustee where the patient is a ward of the Public Trustee, or the nearest relative where the patient is not a ward of the Public Trustee, that the disclosure is essential in the interests of justice.

CHAPTER 5

SUMMARY OF CONCLUSIONS

1. That there appears to be no compelling reason for the courts to recognize a privilege for communications between patients and physicians generally. (para. 2.22)

2. That, notwithstanding conclusion (1), it would be desirable for the courts to recognize a privilege for communications between patients and psychiatrists in appropriate cases. (para. 2.35)

3. That it would be desirable for the courts to recognize a discretionary privilege in regard to communications between patients and other professionals when those professionals perform a counselling function similar to psychiatrists. (para. 2.36)

4. That the Wigmore test, adopted by courts to determine the recognition of privilege for confidential communications generally, provides an appropriate basis for the determination of claims to privilege within the medical field. (para. 4.04)

5. That "The Manitoba Evidence Act" should not be amended to create a presumption that communications between patients and physicians generally are privileged, as contemplated by s. 41 of the Law Reform Commission of Canada's Report on Evidence with respect to federal legislation. (para. 4.08)

6. That s. 26.2(8) of "The Mental Health Act" should be amended by the addition of the following clause:

   (c) where the court, or, in the case of a proceeding not before a court, the Court of Queen's Bench determines, after a hearing from which the public is excluded and that is held on notice to the patient, or (where the patient has not attained the age of majority or is not mentally competent) the Public Trustee where the patient is a ward of the Public Trustee, or the nearest relative where the patient is not a ward of the Public Trustee, that the disclosure is essential in the interests of justice. (para. 4.11)

This is a Report pursuant to subsection 5(3) of "The Law Reform Commission Act", signed this 4th day of October, 1983.

Clifford H.C. Edwards, Chairman

Knox B. Foster, Commissioner

D. Trevor Anderson, Commissioner

George H. Cockwood, Commissioner

Richard Thompson, Commissioner

Geraldine MacNamara, Commissioner

APPENDIX A

SECTION 26.2 OF "THE MENTAL HEALTH ACT", C.C.S.M. cap. M110

Meaning of clinical record

26.2(1) In section 26 and this section, "clinical record" means the clinical record or any part thereof compiled in a psychiatric facility with respect to a patient.

Disclosure of clinical record prohibited

26.2(2) Except as may be otherwise provided in this Act, no person shall disclose, transmit or examine a clinical record.

Exceptions to disclosure

26.2(3) The medical officer in charge of a psychiatric facility in which a clinical record is prepared and maintained, may disclose or transmit the record to, or permit the examination thereof by

(a) any person with the consent of the patient, where the patient has attained the age of majority and is mentally competent; or

(b) any person, where the patient has not attained the age of majority, or is not mentally competent

(i) with the consent of the Public Trustee where the patient is the ward of the Public Trustee, or

(ii) with the consent of the nearest relative, where the patient is not the ward of the Public Trustee; or

(c) any person employed in or on the staff of the psychiatric facility, for the purpose of assessing or treating the patient; or

(d) the medical officer in charge of a health facility or a psychiatric facility currently involved in the direct care of the patient, upon the written request of the medical officer; or

(e) a physician engaged in the direct care of the patient, where the delay in obtaining the consent mentioned in clause (a) or (b) is likely to endanger the mental or physical health of the patient; or

(f) any person for the purpose of research, academic pursuit or the compilation of statistical data where the name and other means of identification of the patient are removed from the records.

Disclosure pursuant to subpoena

26.2(4) Subject to subsections (5) and (6), the medical officer in charge of a psychiatric facility shall disclose, transmit or permit the examination of the clinical record of a patient pursuant to a subpoena, order or direction of a court with respect to a matter in issue before the court under this Act or any other Act of the Legislature.

Statement by attending physician

26.2(5) Where the disclosure, transmittal or examination of a clinical record is required by a subpoena or order under subsection (4) in respect of a matter in issue or that may be in issue in the court and the attending physician of the patient states in writing that he is of the opinion that the disclosure, transmittal or examination of the clinical record or of a specified part of the clinical record

(a) is likely to result in harm to the treatment or recovery of the patient; or

(b) is likely to result in

(i) injury to the mental condition of a third person, or

(ii) bodily harm to a third person;

the medical officer in charge shall comply with the opinion with respect to the clinical record or the part of the clinical record specified by the attending physician except under an order of the court before which the matter is or may be in issue made after a hearing from which the public is excluded and that is held on notice to the attending physician.

Matters to be considered by court or body

26.2(6) On a hearing under subsection (5), the court or body shall consider whether or not the disclosure, transmittal or examination of the clinical record or the part of the clinical record specified by the attending physician

(a) is likely to result in harm to the treatment or recovery of the patient; or

(b) is likely to result in,

(i) injury to the mental condition of a third person, or

(ii) bodily harm to a third person;

and for the purpose the court may examine the clinical record, and, if satisfied that such a result is likely, the court shall not order the disclosure, transmittal or examination unless satisfied that to do so is essential in the interests of justice.

Return of clinical record to officer in charge

26.2(7) Where a clinical record is required pursuant to subsection (4), (5) or (6), the clerk of the court in which the clinical record is admitted in evidence or, if not so admitted, the person to whom the clinical record is transmitted shall return the clinical record to the medical officer in charge forthwith after the determination of the matter in issue in respect of which the clinical record was required.

Disclosure in action or proceeding

26.2(8) Except as provided in subsections (4) and (5), no person shall disclose in an action or proceeding in any court or before any body any knowledge or information in respect of a patient obtained in the course of assessing or treating or assisting in assessing or treating the patient in a psychiatric facility or in the course of his employment in the psychiatric facility except,

(a) where the patient has attained the age of majority and is mentally competent, with the consent of the patient;

(b) where the patient has not attained the age of majority or is not mentally competent, with the consent of the Public Trustee where the patient is a ward of the Public Trustee or the consent of the nearest relative of the patient where the patient is not a ward of the Public Trustee.

APPENDIX B

MENTAL HEALTH ACT, R.S.O. 1980, c. 262, s. 29(9)

29(9) No person shall disclose in an action or proceeding in any court or before any body any knowledge or information in respect of a patient obtained in the course of assessing or treating or assisting in assessing or treating the patient in a psychiatric facility or in the course of his employment in the psychiatric facility except,

(a) where the patient has attained the age of majority and is mentally competent, with the consent of the patient;

(b) where the patient has not attained the age of majority or is not mentally competent, with the consent of the nearest relative of the patient; or

(c) where the court or, in the case of a proceeding not before a court, the Divisional Court determines, after a hearing from which the public is excluded and that is held on notice to the patient or (where the patient has not attained the age of majority or is not mentally competent) the nearest relative of the patient, that the disclosure is essential in the interests of justice.

POOR

QUALITY

ORIGINAL